Massachusetts Department of Public Health
HIV/AIDS Bureau

Ryan White Title II
Consortium Manual

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Acknowledgments

In 2002, the Massachusetts Department of Public Health (MDPH) HIV/AIDS Bureau conducted a process with the purpose of revising the guidelines for Ryan White Title II Consortia in the Commonwealth. This manual is a result of that process. The HIV/AIDS Bureau would like to thank the many people who contributed their time, energy, and expertise to the production of this manual. They are:

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APPENDICES

I. Background

A. Introduction

This manual replaces the Title II HIV Consortia Guidelines, first released in November 1996. Like the original guidelines, this manual is intended to support HIV care consortia in Massachusetts in their efforts to create effective planning processes. Most of the requirements in this document are mandated by the Ryan White CARE Act. The changes outlined in this document reflect the evolution of the HIV/AIDS epidemic and the consortium system in Massachusetts over the last five years. The changes are also a result of ongoing program development and review between community members and the HIV/AIDS Bureau of the Massachusetts Department of Public Health (MDPH).

The information in this manual comes from several sources, including the original Massachusetts Title II HIV Consortia Guidelines, the Ryan White CARE Act Title II Manual and Creating Partnerships That Work (both published by the Health Resources and Services Administration (HRSA)), input from consortium and CAB members around the state, and the experience of HIV/AIDS Bureau staff.

B. Ryan White CARE Act Overview

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act (RWCA) was enacted by Congress in 1990, and then reauthorized by Congress in 1996 and 2000. The purpose of the RWCA is to provide communities and states with money to fund primary health care and support services for people living with HIV/AIDS. More specifically, the RWCA is intended to provide increased access to care for underserved populations and, in general, improve the quality of life of those most deeply affected by the HIV/AIDS epidemic.

The RWCA is divided into five sections, each with a specific purpose:

Title I provides money to urban areas (called Eligible Metropolitan Areas, or EMAs) that have high numbers of reported AIDS cases to fund emergency service needs.

Title II provides money to all states and eligible U.S. territories to improve the quality, availability, and organization of health care and support services for people living with HIV/AIDS and their families.

Title III provides funding to certain organizations, often community health centers, to support outpatient early intervention services (EIS) for people living with HIV/AIDS.

Title IV funds agencies to coordinate services targeted for women, infants, and children living with HIV/AIDS.

Part F funds three kinds of programs: Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETC), and a Dental Reimbursement Program. SPNS funding supports innovative models of HIV/AIDS care that are designed to be replicated by other providers. AETCs provide HIV/AIDS-related education and training for health care providers.

The Dental Reimbursement Program reimburses dental schools and other dental programs for some of the cost of providing dental care to uninsured individuals living with HIV/AIDS.

The Health Resources and Services Administration (HRSA), which is part of the Federal Department of Health and Human Services, is responsible for overseeing the RWCA. *Please refer to Appendix C for a chart that illustrates the flow of RWCA funds*. (The information in this section was adapted from the Ryan White CARE Act Title II Manual.)

C. Roles and Responsibilities

1. Definition of a Consortium

Title II of the RWCA provides money to states to fund non-clinical support services for people living with HIV and AIDS. In Massachusetts, planning for the provision of these services, as well as other state direct funded services, is done by local planning groups called consortia. Each consortium covers a particular geographic area and has a lead agency that administers the funds allocated for services in that area. The lead agency has a contract with MDPH to distribute the Title II funds within the consortium's catchment area (i.e., the area of the state for which the consortium plans services) and MDPH assigns a contract manager to oversee the contract with the lead agency. As of January 2003, there are 20 consortia in Massachusetts.

A consortium is a regional collaborative of HIV/AIDS service providers, other community-based organizations (including substance abuse and mental health providers), consumers, and advocates. According to the language of the RWCA, a consortium must include agencies, at least one public and one private non-profit, that (1) have a record of service to people with HIV and (2) are representative of local populations affected by HIV. (*See page 12, Required Members, for definitions*.)

2. The Role of a Consortium

A consortium's primary role is three-fold. The group must (1) identify gaps in local services by assessing unmet consumer needs and existing service utilization, (2) advise the lead agency and the HIV/AIDS Bureau on local service needs and how best to meet those needs, and (3) prioritize those needs for funding consideration and then make appropriate recommendations to the consortium's contract manager.

By gathering community-wide input through both formal and informal methods (e.g., consortium meetings, consumer advisory boards, public forums, consumer satisfaction surveys, needs assessments), consortia are able to provide the HIV/AIDS Bureau with critical information about the specific needs of their community so that available funding may be used to provide essential services to people living with HIV/AIDS.

The HIV/AIDS Bureau expects and requires a consortium to:

- Serve as a culturally sensitive bridge to provide outreach and access to existing services for individuals and families living with HIV/AIDS;

- Develop a coalition of essential providers, consumers, and community members;

- Assess service needs and identify gaps in services, particularly among those individuals who know their HIV status but are not yet receiving services;

- Plan a continuum of care based on identified consumer needs; and

- Make funding priority recommendations to the lead agency and HIV/AIDS Bureau based on the consortium's service priorities.

A consortium should <u>not</u> conduct any formal quality assurance process for services prioritized for funding by the consortium. Quality assurance is the role of the HIV/AIDS Bureau.

3. <u>The Role of a Lead Agency</u>

The lead agency is the administrative arm of the consortium. The agency plays a critical role in assuring the stability and effectiveness of the consortium.

The HIV/AIDS Bureau expects and requires a lead agency to:

- Manage the fiscal components of the consortium;

- Act as the primary contact with the HIV/AIDS Bureau contract manager;

- Share information from the HIV/AIDS Bureau with consortium members in a timely manner;

- Ask for funding recommendations from the consortium based on the consortium's service priorities;

- Procure subcontracted services, when appropriate;

- Provide administrative support to the consortium and the consortium's consumer advisory board (CAB);

- Provide, at minimum, quarterly reports to the consortium on the status of the contract budgets;

- Provide, at minimum, quarterly reports to the consortium about service utilization data (via the GenuWin software system);

- Provide, at minimum, quarterly reports to the CAB on the status of the CAB budget;

- Provide meeting space, copy machine use, and telephone access to the CAB for CAB business;

- Make financial recommendations to the consortium and HIV/AIDS Bureau regarding reallocations or adjustments to the overall consortium and subcontractor budgets;

- Report fiscal concerns (on the part of the lead agency or a subcontractor) to the contract manager as soon as issues arise;

- Provide the contract manager with a clear written breakdown of funding allocations, as recommended by the consortium, when submitting annual goals and objectives;

- Compile all reporting data, including subcontractor data, and any other requested information and submit semiannual Contract Monitoring and Assessment Reports (CMAR) to the HIV/AIDS Bureau; and

- Maintain an up-to-date, secure, and confidential HIV/AIDS Bureau approved service utilization database.

4. The Role of a Consumer Advisory Board (CAB)

Each consortium is required to have a CAB, which is comprised of consumers, and is responsible for advising the consortium on the needs of consumers within the consortium's catchment area. A consumer is defined by the HIV/AIDS Bureau as an individual living with HIV/AIDS or a parent or guardian of a person under 21 living with HIV/AIDS. A more complete description of the CAB system may be found in the HIV/AIDS Bureau CAB Guidelines, which may be obtained from the HIV/AIDS Bureau Consumer Office.

The HIV/AIDS Bureau expects and requires a CAB to:

- Function as a mechanism for consumer outreach, education, and support in order to assure informed and effective consumer input into the consortium process;

- Provide consumer input into community AIDS service program development;

- Act as a liaison between consumers, the HIV/AIDS Bureau, and community AIDS service providers;

- Educate and bring together people living with HIV/AIDS through a variety of activities that encourage and support consumer activism; and

- Host periodic recruitment events that are designed to foster discussion about service needs and encourage consumers to participate in the CAB.

D. Who's Who at the HIV/AIDS Bureau

1. Contract Manager

The contract manager is the staff person who is responsible for overseeing the contract between the HIV/AIDS Bureau and the consortium's lead agency. The contract manager is

the primary contact for the lead agency and consortium on all contract and budget related issues, including amendments and line item edits, questions about appropriate expenditures, and contract compliance. The contract manager is also the point person for other consortium related issues and, when appropriate, will refer issues to other HIV/AIDS Bureau staff. Depending on staff capacity, a contract manager may oversee a few or several contracts at any time. In addition, if a consortium is unable to meet any of the requirements set out in this manual, the contract manager is the person to consult.

2. Consortium Policy & Planning Coordinator

The policy and planning coordinator provides technical assistance to all consortia in the state on policy and planning matters such as work plans, needs assessments, bylaws, consortium operations, and grievances. This staff person may also provide trainings on various consortium related topics, such as leadership development, effective planning strategies, and member recruitment.

3. Consumer Office

The Consumer Office is the primary contact for all issues related to the CAB. This includes questions about the CAB budget, CAB expenditures, and CAB operations. The Consumer Office is also available to provide technical assistance on CAB development, including leadership, member recruitment and retention, and community activities.

II. Bylaws

A. Purpose

The HIV/AIDS Bureau requires every consortium to have bylaws. Bylaws describe the purpose of the group, how it operates, who can participate, and what is expected of members and leaders. Bylaws serve as a place to turn for answers when questions arise within the group. More importantly, because bylaws are created and amended by the general membership of the group, they help ensure that the membership retains its authority to make decisions about how to advise its funder (in this case, the HIV/AIDS Bureau).

B. Process

Each consortium must nominate a bylaws committee (either standing or ad hoc) that will develop the consortium's bylaws. Because a bylaws committee is composed of only a few people and is focused on a particular task, having a committee is often the most effective and efficient means of drafting this important document. The bylaws committee will then bring its draft to the consortium membership for a vote. At least once every two years, the bylaws committee must also review the bylaws and make recommendations for amendments, if necessary, to the consortium.

The entire general membership of the consortium must have a vote in the adoption and any amendment to the bylaws. It is not enough for the consortium's steering committee or board of directors to approve the document or any changes to it. Every voting member of the consortium must be given ample written notice that a vote on the proposed bylaws is going to be held and must then have an opportunity to cast a vote. After the vote is taken, a copy of the consortium's bylaws and any subsequent revisions must be submitted to the consortium's contract manager for approval.

A consortium may decide that the bylaws can be amended only once a year, for example, at the annual meeting, or the consortium may decide that the bylaws can be amended at any time, provided that members are given ample notice and have an opportunity to discuss the proposed changes.

C. Elements of Bylaws

Bylaws are usually divided into articles, which are then further divided into sections. A consortium can decide for itself what additional information it wants to include in its bylaws, but all bylaws must include descriptions of the following:

- The consortium's mission (beyond what the HIV/AIDS Bureau requires);
- The role of the lead agency;
- The consortium's governing structure (leadership positions, committees, etc.);
- A description of leadership election procedures;
- The roles and responsibilities of the consortium membership;
- Definition of a voting member;
- A procedure for calling an emergency consortium meeting;

- An orientation training plan;
- A description of how information is shared among the consortium, lead agency and CAB;
- Rules about attendance and voting procedures, including quorum;
- A mechanism for amending the bylaws;
- The role of the consumer advisory board;
- A code of conduct for consortium meetings;
- A means of addressing conflicts of interest; and
- Grievance procedures.

III. Consortium Membership

A. Required Members

1. Legislative Requirements

In order for a consortium to meet Federal and state requirements, certain organizations must be members of the consortium. According to the Ryan White CARE Act, a consortium must include health care and support service providers and community-based organizations that (1) have a record of service to people living with HIV, and (2) are representative of populations affected by HIV, according to epidemiological data. The CARE Act also requires that the membership include at least one public entity and one private non-profit entity. A public entity may be a local board of health, a mayor's office, a school board, or any other government or state funded entity.

2. Title II Funded Providers

The MDPH HIV/AIDS Bureau also requires that all agencies receiving funds under the contract between the HIV/AIDS Bureau and the consortium lead agency (including the lead agency and all subcontracted providers) be active members of the consortium. Being an active member of the consortium includes attending consortium meetings.

3. Consumers

People living with HIV (consumers) make up another group that is critical to the consortium process. For purposes of consortium membership, a consumer is any individual who identifies as a person living with HIV/AIDS. The HIV/AIDS Bureau requires that consumers account for at least 25% of the consortium membership and consortium steering committee, if the consortium has one. If a consortium is unable to achieve the required 25% consumer representation, the consortium must make every effort to come as close as possible to the desired percentage, including submission of a written plan that explains the consortium's outreach and recruitment efforts. This plan must be submitted to both the consortium's contract manager and the Consumer Office at the HIV/AIDS Bureau.

B. Recommended Members

Because people living with HIV also receive services from providers whose services are not necessarily HIV-specific, these providers are encouraged to participate in their local consortium. In general, human service providers tend to serve populations that are at risk for HIV infection and, as a result, these providers often provide services to people who are HIV-positive. These providers therefore represent critical linkages for referral and collaboration within an area.

The 2000 reauthorization of the Ryan White CARE Act specifically requires these kinds of linkages. Therefore, consortia are expected to conduct outreach to these kinds of organizations to encourage them to participate in the consortium process.

Examples of these other kinds of agencies or organizations include:

- Substance abuse treatment programs/detoxification centers
- Mental health providers

- HIV Prevention and education providers
- Counseling and testing sites
- Population-specific community-based organizations
- GLBT social and support organizations
- Jails
- Independent living centers
- Legal service providers
- Hospitals/Emergency rooms
- STD clinics
- Representatives from state and local government
- Housing programs
- Faith-based organizations (churches, synagogues, etc.)
- Visiting Nurse Associations
- Homeless shelters
- Emergency services providers (e.g., the American Red Cross, survival centers)

Each consortium must also recruit a diverse membership that reflects the demographics of both the epidemic and the communities within the consortium's catchment area.

C. Definition of Voting Member

A consortium must define in its bylaws who is a voting member of the consortium. Some consortia require that a member attend a certain number of meetings before becoming eligible to vote, while others require only registration (i.e., adding one's name to the official membership list) with the consortium and an orientation in order to vote. Whatever the consortium decides, however, the policy must be made known to all members.

In addition, each agency represented on the consortium is entitled to only one vote. In other words, if several employees of a particular agency attend a consortium meeting, those employees are entitled to one collective vote. This rule applies to any employees of that agency, whether or not they are present specifically to represent the agency. This requirement ensures that no one agency can sway a vote in its own favor. However, this does not apply when the consortium reaches a decision by consensus.

D. Orientation

1. General Requirements

The HIV/AIDS Bureau requires that every consortium have a new member orientation plan. Every new consortium member must go through an orientation that explains the consortium process and describes the member's role within the consortium. The orientation must include an orientation packet, the contents of which are set out below. Without a complete understanding of the consortium's function and purpose, a member cannot fully and effectively participate in the process. Therefore, it is incumbent upon the existing members to orient the new members.

2. Required Elements

One way to help new members become acquainted with the consortium is to provide them with an orientation packet. Such a packet must include the following:

- The consortium's meeting schedule**;**
- A copy of the consortium's mission statement;
- The consortium's bylaws**,** including a conflict of interest policy, grievance procedure, and code of conduct;
- A confidentiality sign-off sheet;
- A list of funded services and agencies for the consortium;
- The consortium's work plan;
- Meeting minutes from the past two meetings;
- A copy of the Massachusetts Ryan White Title II Consortium Manual; and
- Any other information that might be relevant.

The orientation training must occur within 90 days of the new member joining the consortium. The orientation may take place before, during, or after a regularly scheduled consortium meeting, or may be a separate gathering coordinated by the consortium chair, coordinator, lead agency representative, or consortium designee. An explanation of the materials included in the orientation packet, along with an opportunity for new members to ask questions, will be sufficient to meet this requirement. A copy of the orientation packet must be submitted to the consortium's contract manager to have on file.

HIV/AIDS Bureau staff are available to help consortia with creating orientation packets and developing trainings. *For information on how to request technical assistance, refer to Appendix R and page 28 of this manual.*

E. The Role of the Consortium Membership

1. Plan and Coordinate HIV/AIDS Client Services

In general, consortium members are responsible for the planning of MDPH-funded client services within their consortium's catchment area. This planning requires that consortium members determine what services are most needed in their area, prioritize those services for funding, and then make recommendations to the lead agency and MDPH.

a. Assess Consumer Needs (in Conjunction with the CAB)

Every two years, each consortium is required to conduct a needs assessment process that will help determine unmet client service needs and the appropriateness of current funding distributions. This process must include:

1. a review of current service utilization, demographic, and epidemiological data for the consortium's catchment area (all of which may be obtained from the consortium's contract manager);
2. an assessment of consumer satisfaction with MDPH funded services by means of consumer surveys (which must be approved by the consortium and CAB and submitted to the Consumer Office and contract manager) and focus groups;

3. an assessment of unmet client service needs, also by means of consumer surveys and focus groups;
4. a process for determining how to accommodate new or expanded service needs; and
5. a means of identifying the needs of individuals who know their HIV status but are not receiving services.

The staff of the Consumer Office at the HIV/AIDS Bureau is available to assist consortia and CABs with reviewing surveys and developing focus group questions.

For information on how to use data for planning, see Appendices K-N.

b. Prioritize Available Funding

Once consumer need within an area has been determined, recommendations must be made to the contract manager about which services, and how much of each service, should be provided. Core services, as determined by the HIV/AIDS Bureau, must be prioritized. However, if a consortium feels that it is not necessary to fund one of the core services, the consortium must explain to its contract manager how that core service is provided elsewhere (e.g., another agency or program provides the service) or why that core service is not appropriate or necessary within the catchment area. The rationale must be documented and submitted in writing. After the core services are prioritized, other available services (e.g., mental health treatment, legal services, drop-in centers) may be considered. Once priorities have been finalized, the consortium, through its lead agency, makes recommendations to the contract manager.

Final funding allocation decisions are made by HIV/AIDS Bureau staff.

c. Review of Success

The RWCA requires that each consortium periodically review its own success in responding to identified consumer needs. This review must include a review of the cost-effectiveness of the service delivery mechanisms recommended by the consortium. In other words, the consortium must determine whether or not its recommendations for service priorities have served the community well. The HIV/AIDS Bureau requires that each consortium undertake this review at least once every two years.

2. Create Linkages

A consortium is responsible for reaching out to other client service providers and creating linkages that will help facilitate referral and collaboration, which help to create a continuum of care. Every consortium member is responsible for helping to ensure that these linkages are created. In addition, membership development must be a regular part of consortium meetings.

IV. Consortium Leadership

A. Leadership Structure

Each consortium may determine for itself how to set up its governing structure. However, no governing structure may interfere with the true intent of the consortium, which is to be an inclusive and collaborative planning body.

Most consortia operate with only a general membership led by one or two chairpersons. The entire consortium meets on a regular basis and works as a whole to address all consortium issues. **This is the recommended model**. This model ensures that every member of the consortium has an equal opportunity to participate in the planning process.

Some consortia, however, have chosen to utilize an elected subgroup of the consortium that tends to the consortium's day-to-day business. This subgroup is usually referred to as a steering committee or a board of directors. The purpose of this structure is to reinforce a commitment from those who choose to be involved in the consortium's regular business while allowing those who do not wish to be as involved the option of participating at a less intensive level. The general membership, which meets less frequently, comes together to tackle the important planning issues that pertain to the consortium as a whole.

The potential problem with an elected subgroup is that some people who want to participate, but are not elected, will effectively be excluded from a process that is supposed to be open to anyone who fits the consortium's membership requirements. Any exclusion from the consortium process is contrary to the HIV/AIDS Bureau's philosophy of community planning.

Therefore, if a consortium chooses to utilize a subgroup model, the subgroup must be open to anyone who wishes to participate. To ensure commitment from participants, the consortium may structure its bylaws to accommodate various levels of membership. For example, a consortium may choose to have general members, who do not have voting privileges and participate sporadically, and voting members, who participate regularly and have attained voting privileges by attending a certain number of consecutive meetings.

B. Chairs

1. Requirements

a. Role

The HIV/AIDS Bureau requires that each consortium have at least one chairperson who is responsible for guiding the group toward its mission. In that role, the consortium chair may have several responsibilities, including leading consortium meetings, overseeing needs assessments, organizing activities, attending HIV/AIDS Bureau-sponsored events, participating in the Massachusetts Association of Title II HIV Care Consortia (MATHCC), and serving as the consortium spokesperson. The chair may also choose to delegate some responsibilities to other consortium members.

The consortium may determine for itself who is eligible to be the chair, however **an employee of the consortium's lead agency, or a member of the lead agency's board of directors, may <u>not</u> serve as the consortium chair, co-chair, or vice chair.**

b. Election

The entire general voting membership of the consortium must be given an opportunity to vote for the consortium chairs. Even if the consortium chooses to have a steering committee or, in some cases, a board of directors to tend to the consortium's day-to-day business, the entire general membership must still have the opportunity to vote for the chairs. This requirement exists to prevent any actual or perceived conflict of interest.

2. Leadership Models

A consortium may decide for itself what kind of leadership model it wants to employ. The consortium may choose to elect two equal co-chairs who share responsibilities and are elected either at the same time or in alternating years. Another option is to elect a chair and a vice chair. In some consortia, the vice chair may be the person who automatically becomes chair when the chair's term expires. In other consortia, the vice chair may be a completely separate position. Smaller consortia, which may not have a large enough membership to necessitate two leaders, may choose to elect only one chairperson.

It is strongly recommended that the term of office for a chairperson be limited to one year and that new elections take place each year. The consortium must decide for itself how many terms a chair may serve.

Whatever leadership model a consortium chooses, it must be described explicitly in the consortium's bylaws.

C. Lead Agency Representative

Because the consortium works with a lead agency, which serves as the fiscal and administrative arm of the consortium, the lead agency is required to send a representative to the consortium meetings. This representative is usually the HIV services program manager, but could also be someone from the agency's fiscal office, or some other employee designated to fill the role. The lead agency representative must be someone in a supervisory position and must have decision-making authority. A case manager or other direct service provider is not an appropriate representative of the lead agency.

At consortium meetings, the lead agency representative is responsible for giving updates on the consortium's budget and service utilization and for sharing information from the HIV/AIDS Bureau with the consortium membership. The representative must be in regular contact with the consortium's contract manager in order to be apprised of information that must be shared with the consortium. The representative may also choose to participate in consortium committees and other consortium activities, as long as no conflict of interest exists (e.g., if the work or decisions of the committee would benefit the lead agency in some way).

D. Consortium Coordinator

In order to avoid any actual or perceived conflict of interest, it is strongly recommended that the lead agency representative not serve as the consortium coordinator. Lead agencies are strongly encouraged to hire an additional staff person to take on the responsibilities of the consortium coordinator position.

The responsibilities of the coordinator position vary from consortium to consortium. However, no matter how a consortium opts to configure its coordinator position, some basic characteristics and functions are common to almost all coordinators. For example, the coordinator is usually an employee of the lead agency. This is not required, but most consortia find that this arrangement is fiscally and administratively more manageable than having the coordinator employed elsewhere. Also, the coordinator usually serves a primarily administrative and clerical role. The coordinator is usually responsible for doing consortium mailings, taking minutes at meetings, distributing minutes, making copies of other information to distribute at consortium meetings, and other tasks as requested by the consortium. In some cases, however, the coordinator also performs some program related responsibilities, including organizing and coordinating needs assessments and work plans, and serving as the consortium representative at statewide planning meetings.

E. Consumer Advisory Board (CAB) Chair

The CAB chair is responsible for running CAB meetings and maintaining contact with the lead agency and often serves as the primary liaison between the consortium and the CAB. The CAB chair, or the chair's designee, is expected to represent the CAB at consortium meetings and bring information back and forth between the consortium and CAB.

V. Consortium Meetings

A. General Requirements

1. Meeting Frequency

The HIV/AIDS Bureau requires that a consortium meet at least four times per year. Beyond that, a consortium may choose to meet as often as it likes (e.g., every month, every other month) depending on its needs. Each consortium must also have a regular meeting schedule so that members and other participants know when to attend. For example, a consortium may choose to meet on the second Tuesday of every month, or the third Wednesday every other month, or whatever works best for the majority of members. The meeting schedule must be made available to all members.

2. Agenda

An agenda is a description or list of activities that are going to occur at a meeting. A consortium must have an agenda for each meeting so that all participants know what to expect during the meeting and understand when their participation will be necessary. An agenda helps organize the meeting and make it run more smoothly. For consortium meetings, an agenda must include time for the CAB report. *See Appendix D for a sample agenda.*

3. Minutes

The minutes serve as the official written record of a meeting. A consortium must record minutes for every meeting so that they may be referred to in the future when information from a past meeting becomes important. The minutes must then be distributed to all consortium members and CAB designee and be approved (with corrections, if necessary) at the next consortium meeting. In addition, each consortium is required to submit a copy of the minutes from each meeting to the consortium's contract manager as soon as the minutes have been approved by the consortium. *For tips on taking minutes, see Appendix I.*

4. Confidentiality Policy

Because consortium meetings are open and public meetings, information shared at meetings cannot be protected by confidentiality. Therefore, it is critical that confidential information remain confidential. Confidential information includes, but is not limited to, information about a person's health or HIV status, employment situation, or involvement in a survey or focus group. Each consortium is required to have a written confidentiality policy that is made available to all members, is included in the new member orientation packet, and is acknowledged at some point during each meeting. The policy may be read at the beginning of each meeting, posted on the wall during the meeting, or included as part of signing in on the attendance sheet. Members must pledge not to share any confidential information, particularly about consumers, that they are not at liberty to share with the group. Any questions that arise around confidentiality should be directed to the consortium's contract manager or to the Consumer Office at the HIV/AIDS Bureau. *See Appendix J for a sample confidentiality sign-off.*

B. Making Recommendations

1. General Requirements

A consortium's primary responsibility is to make recommendations to the lead agency and the HIV/AIDS Bureau about how best to prioritize client services for funding. In order to make these recommendations, the consortium must first come to some sort of agreement within the group. There are two ways to reach an agreement: consensus building and voting. With consensus building, the agreement among the group members does not require a formal vote and is often a time-consuming, but worthwhile, process. As with votes, a quorum (see below) must be present for consensus and decisions reached by consensus must be recorded in the meeting minutes. *For more information on consensus building, refer to Appendix F.* Although consensus building is something to strive for, there are going to be times when a consensus cannot be reached or when a formal vote is more appropriate.

2. Requirements for Voting

A consortium is required to do the following: (1) clearly articulate the voting procedure in the consortium's bylaws, (2) be consistent by using the same voting procedure for every vote at every meeting, (3) have a **quorum** present for the vote, and (4) use a ballot (paper) vote for sensitive issues in order not to single out any individual at the table. *For an example of a formal voting procedure, refer to Appendix G.*

A **quorum** is the number of people who must be present in order for a vote to be taken. The consortium's bylaws must set out how many people are needed to make a quorum. In some cases, a consortium may choose to use a number (e.g., 10 voting members). In other cases, a consortium may choose to use a percentage (e.g., 51% of the voting membership). Using a percentage, however, is difficult because it requires that the consortium know exactly how many voting members it has. The number of people required to make a quorum will vary depending on the size of the consortium. Requiring a quorum for a vote ensures that enough members have input into important decisions.

All major decisions must be discussed and voted on by the entire general voting membership of the consortium. No one may be excluded. Major decisions include, but are not limited to:

- Electing consortium officers;
- Making recommendations to fund or defund a service (scope of service change);
- Approving the consortium work plan; and
- Amending the consortium bylaws.

If the consortium has a steering committee or board of directors to handle the consortium's day-do-day business, it must still make all major decisions open to a discussion and vote by the entire consortium membership. If there is any question about whether or not a decision is major, hold off on the vote and contact the consortium's contract manager for guidance.

Furthermore, prior to any meeting at which a vote on a major decision will be taken, all consortium members must be notified that the vote is going to take place at the next meeting. The consortium must also have a written procedure for notification that includes notifying the consortium's contract manager.

C. Role of the Chair

The chair of the consortium generally serves as the meeting leader. In the absence of chair, the vice chair or co-chair will most likely be the meeting leader. As the meeting leader, the chair is responsible for facilitating the meeting. *For pointers on meeting facilitation, see Appendix E.*

D. Appropriate Expenditures

Each consortium budget includes a consortium support line item from which certain expenditures may be drawn. Appropriate expenditures from this line are all related to consortium meetings and include the following:

- Consortium coordinator position;
- Volunteer expenses and stipends for consumers attending consortium meetings;
- Food and other supplies for consortium meetings;
- Photocopying;
- Postage and shipping;
- Advertising and announcements; and
- Public events (e.g., fee for booth at health fair).

If a consortium would like to spend money on any item or activity not mentioned above, the consortium must ask for and receive written approval from the consortium's contract manager at the HIV/AIDS Bureau.

VI. Consumer Advisory Board (CAB)

A. Requirements

1. Annual Plan

At the beginning of each state fiscal year (July 1), every CAB is required to submit a brief annual plan that describes the CAB's proposed projects and anticipated budget for the year. The plan must be submitted to the consortium and the Consumer Office at the HIV/AIDS Bureau. However, it is not the consortium's role to approve or disapprove of the CAB's plan. If there is any question about the appropriateness of the CAB's plan, contact the Consumer Office. The Consumer Office is also available to provide technical assistance to CABs as they develop their plans.

2. Meetings and Minutes

Every CAB is required to meet at least four times per year. At each meeting, minutes must be recorded and then forwarded to the Consumer Office at the HIV/AIDS Bureau. A report about the CAB meeting must be given at the next consortium meeting.

For a more complete description of the CAB's role, refer to page 8, The Role of a Consumer Advisory Board.

B. The Consortium's Responsibility to the CAB

The consortium is required to recruit, support, and maintain a CAB. Because a consortium cannot effectively do its job without consumer input, it is up to the consortium to ensure that consumer input is available at all times. Once a CAB is in place, however, it is usually more effective for the CAB members themselves to recruit additional members. That said, it is still the consortium's responsibility to assist the CAB with recruitment efforts and support the CAB through various projects. The consortium, along with the lead agency, is also responsible for securing meeting space for the CAB, as well as assuring access to a copy machine and phone for CAB business

C. Membership

Membership requirements for a CAB are usually determined by the existing CAB members. CABs are expected to hold periodic recruitment events that are designed to explain the purpose of the CAB and encourage consumers to join. In almost all cases, the CAB consists entirely of people living with HIV. However, some CABs also include parents or guardians of minors living with HIV or partners of adults living with HIV who cannot attend CAB meetings.

D. Budget

1. Role of the Lead Agency

Each CAB has its own budget, which is administered by the consortium's lead agency. The lead agency must allow the CAB to establish its own budget line items and is then responsible for notifying the CAB when a line is in danger of being overdrawn or when funds need to be moved from one line to another. The lead agency is also responsible for providing

budget updates to the CAB at least quarterly, monitoring the appropriateness of CAB expenditures, ensuring that all expenditures are adequately documented, developing a relatively simple procedure for CAB members to gain access to CAB funds, responding to requests for funds, and making reimbursements within a reasonable amount of time. Ultimately, unless a proposed expenditure is clearly inappropriate, the lead agency is encouraged not to interfere with how the CAB chooses to spend its funds. If the lead agency has any questions about the use of the CAB budget, the lead agency representative may call the HIV/AIDS Bureau Consumer Office or the consortium's contract manager.

2. Appropriate Expenditures

CAB funds may be used for the following expenses:

- Transportation to and from CAB meetings;
- Child care while the parent is attending a CAB meeting;
- Language interpretation at CAB meetings;
- Refreshments for CAB meetings;
- Mailings and postage;
- Recruitment efforts;
- Education activities; and
- Stipends for attending CAB meetings (up to a maximum amount, as determined by the Consumer Office). Distribution of stipends must be documented in some way (e.g., consumers sign for them).

If a CAB would like to spend money on any item or activity not mentioned above, the CAB must ask for and receive written approval from the Consumer Office at the HIV/AIDS Bureau.

VII. Lead Agency

A. Role

The lead agency serves as the legally and financially responsible entity between the HIV/AIDS Bureau and the client services subcontractors receiving funds through the consortium process. In this role, the lead agency has several specific responsibilities, all of which are described on page 7 of this manual.

A lead agency is expected to serve the full term of the contract with the HIV/AIDS Bureau. However, although the HIV/AIDS Bureau discourages a lead agency change during the contract period, a change may be permitted if there is supported evidence of lead agency mismanagement, as determined by the HIV/AIDS Bureau, or there is a change in the lead agency's organizational or fiscal circumstances, as identified by the lead agency, such that it can no longer carry out its consortium support duties.

B. Models

Although the lead agency always serves the same function in relation to the consortium, the lead agency does not always look the same. There are three lead agency models in Massachusetts:

1. The lead agency is a service provider and is one of many service providers in the area;
2. The lead agency is a service provider and is the sole or primary service provider in the area; or
3. The lead agency is not a service provider.

In some areas of the state where there are fewer providers, a consortium may be limited in its choice about the lead agency model it utilizes. In other areas, where a consortium does have a choice, the decision will vary based on the particular needs of the consortium.

C. Performance Review

Every year, the HIV/AIDS Bureau conducts a performance review of each lead agency. This process includes a review of the agency's fiscal management, data collection and reporting procedures, and other contract compliance issues. In addition, each consortium is expected to do its own annual assessment, which includes an objective review of the lead agency's performance. This review by the consortium, however, includes only those functions for which the lead agency is explicitly responsible (i.e., those issues that are part of the lead agency's contract with the HIV/AIDS Bureau). The review must not include philosophical or personal differences between the consortium and lead agency. The review must be conducted by the entire consortium and the results submitted to the consortium's contract manager. If the consortium prefers, the review itself may be conducted by a subcommittee, as long as the results of the review are brought back to the entire consortium for discussion and approval before submission to the contract manager. The HIV/AIDS Bureau has developed a performance assessment tool for consortia to use in this process. *Please refer to Appendix O for a copy of this tool.*

VIII. Conflict of Interest

A. Requirements

Each consortium must have a written conflict of interest policy that describes how and when a conflict might arise and requires consortium members to disclose conflicts of interest, whether actual or perceived, before a discussion or vote on the topic takes place. The consortium may (by consensus or vote) also request that the individual with the conflict leave the room during the discussion and/or vote. *See Appendix P for a sample conflict of interest policy.*

The conflict of interest policy must be reviewed with the membership at the beginning of each meeting to remind members that they have an obligation to disclose any conflict and to provide members with an opportunity to make any disclosures. The conflict of interest policy must be included in the consortium's new member orientation packet and must be on file with the consortium's contract manager.

A consortium should ask the HIV/AIDS Bureau for assistance with a conflict of interest only when the consortium's own internal procedure does not yield a satisfactory result. If this situation occurs, the chair of the consortium (or other consortium representative if the conflict involves the chair) should contact the consortium's contract manager at the HIV/AIDS Bureau for technical assistance. The request for technical assistance must be in writing. If technical assistance alone does not help resolve the problem, the consortium may ask the contract manager or other HIV/AIDS Bureau staff to mediate the situation. Once a request has been made to the HIV/AIDS Bureau for mediation and the Bureau gets involved in the situation, the Bureau's decision on the outcome of the situation will be final.

B. Description

A conflict of interest occurs when a consortium member has a direct or indirect financial or professional interest in a consortium decision or the outcome of a vote. The interest in the outcome of a decision or vote may be actual or perceived. In other words, even if a consortium member does not actually have an interest in an outcome, the possibility that this person might have an interest is often enough to make the other consortium members question that person's motivation. There can also be a conflict of interest if consortium members use their position on the consortium to gain a benefit for themselves, their friends, or their businesses.

Another kind of conflict of interest arises when a meeting or discussion is led by a member who might have an interest in the outcome of a discussion or vote. This is why an employee of the lead agency may not serve as chair or co-chair of the consortium. It is generally assumed that the lead agency, as the fiscal branch of the consortium, has an interest in the outcome of most discussions and votes, particularly those around funding. For the same reason, a member of the lead agency's board of directors is also prohibited from serving as the consortium chair or co-chair.

IX. Grievances

A. Requirements

The HIV/AIDS Bureau requires that every consortium have a clear and concise written grievance procedure that is made available to all consortium members. A grievance procedure is a step-by-step description of how a grievance is raised and addressed. Grievance procedures may vary, but each must include a requirement that the grievance must be submitted in writing. Further, the entire grievance process, from beginning to end, must be documented in writing. Each consortium must also have a grievance committee that exists for the sole purpose of hearing and addressing grievances brought by consortium members. This committee may be either standing or ad hoc. If a grievance committee member has any connection to the problem being addressed (i.e., the member has a conflict of interest), that person must refrain from participating in the process for that particular complaint. *See Appendix Q for a sample grievance procedure.*

A consortium should ask the HIV/AIDS Bureau for assistance with a grievance only when the consortium's grievance procedure does not yield a satisfactory result. If this situation occurs, the chair of the consortium or the consortium's grievance committee should contact the consortium's contract manager at the HIV/AIDS Bureau for technical assistance. The request for technical assistance must be in writing. If technical assistance alone does not help resolve the problem, the consortium may ask the contract manager or other HIV/AIDS Bureau staff to mediate the situation. Once a request has been made to the HIV/AIDS Bureau for mediation, and the Bureau gets involved in the grievance, the Bureau's decision on the outcome of the grievance will be final.

B. Description

A grievance is an expression of dissatisfaction with a decision that has been made or with the way some activity has been carried out. The best way to handle a grievance or potential grievance is to prevent it in the first place. Grievances may be prevented if the consortium engages in consistent, open, and fair practices that allow for a wide array of input. Whether or not a consortium works to prevent grievances, a consortium member may still feel that a particular decision or action was unfair. If this is the case, it would be preferable for the consortium to handle the situation informally by talking openly about it and trying to reach some kind of resolution. If this informal method does not work, the person with the grievance must utilize the consortium's grievance procedure to register the concern more formally.

C. Types of Grievances

Grievances fall into three categories: (1) a consortium member complaint about consortium processes or decisions, (2) an agency complaint about a consortium funding recommendation, or (3) a complaint about access to or quality of services.

Only numbers 1 and 2 above are appropriate issues for a consortium grievance process. Examples include complaints about how leadership was elected, how a particular vote was taken, or how the consortium recommended funding for one agency or service over another. Number 3 above, however, is not the kind of issue that consortium grievance procedures may address.

Complaints about services or about a particular service provider are not appropriate grievances to be brought before the consortium. If an individual has a problem with a particular service or provider at a particular agency, that individual must utilize that agency's grievance procedure.

X. Technical Assistance

A. When to Seek Technical Assistance

1. General Questions

Any time a consortium has a question about its own general operations, a call to the HIV/AIDS Bureau would be appropriate. A consortium may ask questions about meeting procedures, membership and leadership issues, general conduct, confidentiality, and any other topic that comes up.

2. Bylaws Revisions

A consortium is free to amend its own bylaws, according to the procedures set out in the bylaws. However, when a consortium decides to undertake a major bylaws revision, technical assistance from the HIV/AIDS Bureau would be appropriate. Once amendments are made, the new bylaws must be submitted to the consortium's contract manager. *See page 10 for further information on bylaws.*

3. Conflicts that Cannot Be Resolved Within the Group

There are going to be times when a conflict arises within a consortium that the consortium is unable to resolve on its own. When this occurs, the consortium chair or other consortium representative should request technical assistance and/or mediation, whichever is most appropriate for the situation

4. HIV/AIDS Bureau Requirements

If at any time a consortium feels that, for whatever reason, it is unable to comply with the requirements of the HIV/AIDS Bureau, as set out in this manual, the consortium chair or lead agency representative should contact the consortium's contract manager.

B. What the HIV/AIDS Bureau Offers

1. Consultations over the Phone

The easiest way to ask for and receive technical assistance is to call. Most times, the questions can be answered over the phone and no further assistance is required. HIV/AIDS Bureau staff are always available to discuss consortium and CAB issues over the phone and make every effort to return phone calls within 24 hours.

2. Written Recommendations

When a question is not simple enough to be answered in a conversation over the phone, the consortium representative may request, or the HIV/AIDS Bureau staff may suggest, some written recommendations. Such a request may include assistance with bylaws revisions, an explanation of HIV/AIDS Bureau policy, or anything else that would best be addressed in writing.

3. Attendance at Consortium or CAB Meetings

HIV/AIDS Bureau staff will make every effort to attend consortium or CAB meetings when the consortium or CAB requests staff presence. It is often helpful to have an HIV/AIDS Bureau staff person present at a meeting to answer questions on the spot. A consortium or

CAB may invite HIV/AIDS Bureau staff to a meeting, or HIV/AIDS Bureau staff may suggest to the group representative that staff presence may be helpful.

4. Trainings

The HIV/AIDS Bureau offers several trainings for consortium and CAB members, including basic trainings on how to be an effective planning group, how to run effective meetings, and how to foster effective leadership. If a consortium or CAB would like to have HIV/AIDS Bureau staff provide a training, the consortium or CAB representative simply needs to call the HIV/AIDS Bureau and make the request. Depending on interest and demand, the trainings may be either local or regional. Furthermore, some trainings offered by the HIV/AIDS Bureau are required. For a list of required trainings, contact your consortium's contract manager.

Appendix A: Description of HIV/AIDS Bureau Goals and Programs

The Massachusetts Department of Public Health HIV/AIDS Bureau's programmatic goals are to:

- Increase the number of persons at risk who know their HIV status;
- Decrease the number of new HIV infections; and
- Increase the health and quality of life for those who are infected and high-risk uninfected persons.

Our programs and our dedicated employees strive to promote full access to services for persons most at risk for HIV infection, and those living with HIV/AIDS. In order to accomplish this mission, the Bureau operates three programmatic units and two support units.

Programmatic Units

Client Services
The Client Services Unit oversees the provision of an array of support services for people living with HIV/AIDS and for their families. These services include, among others, case management, meals, transportation, childcare, alternative therapy, and housing for people in transition. The goals of these support services are both to assure access to appropriate HIV clinical care and to maximize the ability of people with HIV/AIDS to live with dignity and support in the least restrictive community setting. Programs are defined by geographical and/or funding parameters and consist of Boston-based services, regional consortia-based services, and housing services.

Health Services
The Health Services Unit oversees four programs that provide primarily clinical services for persons living with HIV/AIDS: the ACT Now and Community Health Centers, Corrections, Counseling and Testing, and Home Health. Health Services strives to enhance the access of high-risk populations to culturally, linguistically, and population competent HIV/STD counseling and testing, primary care, and supportive psychosocial services. Projects within this unit focus on development and evaluation of health care services that respond to the evolving diagnostic, clinical and psychosocial support needs and resources of persons living with HIV/AIDS.

Prevention & Education
The purpose of the Prevention and Education Unit is to develop supportive relationships with a network of community based providers in order to deliver targeted, effective, sustained, theory-based AIDS prevention interventions to individuals and communities at high risk of HIV infection. The overall goal is to reduce the levels of HIV risk behavior among these individuals, to reduce the incidence of new HIV infections, and to address the complex factors that contribute to risk in communities.

Support Units

Policy & Planning
The Policy and Planning Unit is responsible for development of programmatic policy, planning, evaluation, training, and public information. Acting in a support capacity, this unit works closely with the three program units, frequently facilitating inter-unit collaboration. Unit staff also manage the HIV Drug Assistance Program and other special projects. A majority of the work involves oversight of contracts for need assessments, evaluation, and training. The Consumer Office is also housed in this unit.

Administration & Finance
The Administration and Finance Unit provides the central support for all budgetary, contract and procurement, information technology services (ITS), and personnel and operations functions in the HIV/AIDS Bureau. Staff act as point persons and liaisons to MDPH central systems including the Office of Budget, Accounting, Purchase of Service, central ITS, and Personnel and Human Resources. Staff in the program units use this unit as direct contact staff for all of these major central functions.

Appendix B: Glossary

ADAP (AIDS Drug Assistance Program) A state-based program, funded in part by Title II of the Ryan White CARE Act, that pays for drug therapies to treat HIV disease (also referred to as HDAP, or HIV Drug Assistance Program).

AIDS Acquired Immune Deficiency Syndrome.

ASO (AIDS Service Organization) An organization that provides services for people living with HIV/AIDS.

BSAS Bureau of Substance Abuse Services (within MDPH).

Bylaws The document that describes the consortium's operating procedures.

CAB (Consumer Advisory Board) A group of consumers who advise an agency or consortium on how best to provide HIV-related support services.

Catchment Area The geographic region within the state for which a consortium plans services.

CBO (Community Based Organization) A locally based service organization that provides social services at a community level.

CDC (Centers for Disease Control and Prevention) The Federal agency responsible for promoting health and quality of life by preventing and controlling disease. The CDC is the primary funder of MDPH prevention programs.

Consortium A community-based planning group made up of providers, consumers, and other individuals who meet regularly to assess consumer need and prioritize support services for funding.

Consumer A person living with HIV/AIDS or the parent or guardian of a person under 21 living with HIV/AIDS.

Contract Manager The HIV/AIDS Bureau staff person responsible for overseeing the contract between the HIV/AIDS Bureau and the consortium's lead agency.

Demographic Data Information about individuals who use HIV-related support services. This information includes where the person lives or receives services, the person's race, gender, and age, as well as how the person contracted HIV. Demographic data does not include names.

Epidemiological Data Information about the trends of the HIV epidemic, including the number of people who have ever been diagnosed with HIV/AIDS and the number of people currently living with HIV/AIDS. Epidemiological data does not include names.

HIV (Human Immunodeficiency Virus) The virus that causes AIDS.

HIV/AIDS Bureau The division of the MDPH responsible for overseeing the RWCA grant and other state funds allocated for AIDS services.

HOPWA (Housing Opportunities for People with AIDS) A HUD program that provides funding for housing, housing assistance, and housing-related services for people living with HIV/AIDS.

HRSA (Health Resources and Services Administration) The Federal agency responsible for administering the RWCA.

HUD (Housing and Urban Development) The Federal agency responsible for housing-related services.

IDU Injection Drug User.

Lead Agency The ASO or CBO that holds a contract with the HIV/AIDS Bureau and serves as the administrative and fiscal arm of the consortium.

MATHCC (Massachusetts Association of Title II HIV Care Consortia) The statewide planning and advocacy group made up of consortium and CAB members from across the state.

MDPH (Massachusetts Department of Public Health) The state agency responsible for administering the state's RWCA grant.

MPPG Massachusetts Prevention Planning Group.

MSM (Men who have Sex with Men) This term includes men who identify as gay or bisexual, and men who have sex with other men but do not identify as gay or bisexual.

Needs Assessment An assessment of consumer need for HIV-related support services.

Provider An agency or organization that provides support services for consumers.

RFP/RFR (Request for Proposals/Responses) The competitive process used by MDPH to select individuals or agencies to provide services.

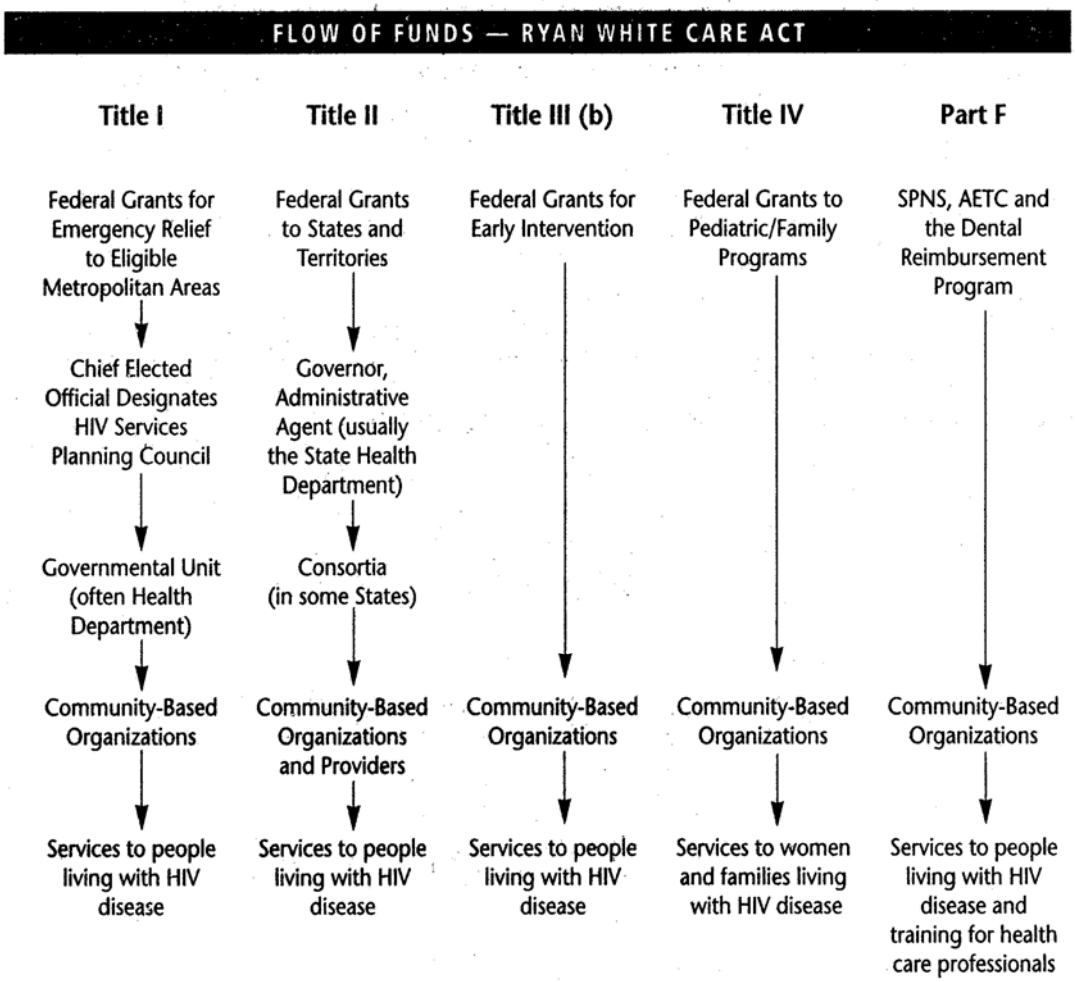
RWCA (Ryan White CARE Act) The federal law that provides funding for AIDS services.

Utilization Data Information about what HIV-related support services are being used, how often they are being used, and where they are being used. Utilization data does not include names.

Work Plan A document that describes the planning activities a consortium or CAB will undertake.

Appendix C: White Ryan CARE Act Funding Flow Chart

The chart below illustrates how the **flow of CARE Act funds** varies by Title.



From Ryan White CARE Act Title II Manual (Health Resources and Services Administration).

Appendix D: Sample Meeting Agenda

Below is a list of items that would be helpful to include on a meeting agenda. Whenever possible, the agenda should be assembled and distributed well in advance of the meeting. This will give members ample opportunity to prepare for the meeting.

Welcome. This is the time when the meeting facilitator (usually the chair) will call the meeting to order and welcome members and guests. This is also a time when the facilitator may solicit changes and additions to the meeting agenda.

Reminders. At the very beginning of the meeting, it is important to remind members about the consortium's confidentiality policy, conflict of interest policy, code of conduct, and voting procedures (including quorum).

Introductions. This is always an important step, especially when new members and guests are present. Attendees usually find it easier and more comfortable to participate when they know who the other people at the table are.

Review and approval of minutes from last meeting. This is the group's opportunity to confirm or not confirm the report of what happened at the last meeting. This is important in order to ensure that there is an accurate record of all meetings.

Reports. This is when various consortium subgroups (e.g., lead agency, CAB, committees) have an opportunity to report back to the main group about what they have been doing and whether or not they have any news to report.

Old business. This item gives the group the opportunity to revisit any issues from previous meetings that have yet to be resolved.

New business. This section of the agenda allows the group to bring up new issues that have yet to be discussed.

Presentations. This is the time during which any members or invited guests would have the opportunity to give a presentation about a particular topic of interest to the group.

Announcements and information sharing. This is when group members may announce upcoming events, items of interest, the time and date of the next meeting, etc.

Adjournment. At this time, the chair may or may not ask for a motion to adjourn and then, after a vote if the group's bylaws require one, officially end the meeting.

Appendix E: Pointers on Meeting Facilitation

Below are some pointers to help the meeting facilitator (usually the chair) keep the meeting running smoothly.

- **Call the meeting to order**. The facilitator is the person who will decide when to begin the meeting.

- **Move through the agenda**. It is the facilitator's responsibility to ensure that the meeting moves smoothly and does not remain on any one topic for too long.

- **Recognize people who want to speak**. The facilitator decides who may speak and when they may speak so that several people are not all speaking at the same time.

- **Acknowledge motions**. Once a motion has been made by a group member, the facilitator must acknowledge the motion and ask if anyone wants to second the motion. If there is a second, the chair must ask if there is any further discussion and then be sure that the group follows established voting procedure when acting on the motion.

- **Keep track of time**. Most people have busy schedules and therefore allow a certain amount of time to be present at a meeting. It is the facilitator's job to ensure that the meeting runs at a fluid pace and does not run over time.

- **Close the meeting**. In some cases, the facilitator will request a motion to adjourn. In other cases, the facilitator will simply end the meeting if no one has anything else to say.

Appendix F: Consensus Building

The Merriam-Webster Collegiate Dictionary (10th ed. 1993) defines ***consensus*** as:

1. a. general agreement
   b. the judgment arrived at by most or all of those concerned

2. group solidarity in sentiment and belief

In a large planning body such as a consortium, general agreement and group solidarity should be the goals. These goals will help to ensure that no member of the group feels isolated or left out of the process. When striving for consensus, every member of the group has an opportunity to play a role in the group's decision making. In order for consensus to work, however, group members must be willing to compromise.

In order for consensus building to be effective, group members must:

- Feel free to express his or her opinion;
- Understand the topic being discussed;
- Stay on task;
- Realize that disagreement is acceptable and expected;
- Separate issues from personalities; and
- Be willing to spend time on the process.

Below are some suggested procedural steps for building consensus:

- Agree on the group's objectives and expectations;
- Define the decision that must be reached by consensus;
- Contribute ideas for solutions that will help the group reach a decision;
- Prioritize the list of possible solutions and discuss the pros and cons of each;
- Compromise; and
- Make a decision.

In some groups and in some situations, consensus is not always possible. When consensus becomes an unreachable goal, a formal voting process will be necessary. *See Appendix G for pointers on voting procedures.*

Appendix G: Suggested Voting Procedures

Although consortium members should strive to reach a consensus on most issues (see Appendix F), consensus is not always possible or appropriate. There will be times when a formal vote will be necessary (e.g., election of officers). For those instances, a consortium must have a written voting procedure set out in the consortium's bylaws. Below are some suggestions for a voting procedure that will ensure both fairness and opportunity for participation.

1. The chair makes sure that a *quorum* is present. A quorum is the number of voting members who must be present in order to take a vote. This number must be set out in the consortium's bylaws.

2. A member of the consortium (other than the chair) makes a *motion* that a vote should be taken.

3. Another member of the consortium (other than the chair) *seconds* the motion. This ensures that the decision to take a vote is not made by one person alone.

4. The topic is opened for further *discussion*.

5. Once discussion is complete, a *vote* is taken.

6. Depending on how many people vote for or against the motion, the motion will either carry or fail. Most consortia require only a simple majority (more than half) for a motion to carry (i.e., for the vote to be successful). If a majority is not reached, the motion fails.

7. The results of the vote are then *recorded* in the meeting minutes.

Appendix H: Sample Code of Conduct

Once the consortium meeting is called to order, all persons present shall preserve the decorum of the meeting. This means that all persons must conduct themselves in a manner consistent with good taste and generally accepted standards of appropriate behavior.

Persons present at the meeting may not make derogatory remarks about another person, use rude or offensive language (swears, etc.), or disrupt the course of the meeting.

Persons present at the meeting are expected to respect the opinions of others (even if they disagree) and engage in open and productive discussions.

Any person who violates these rules will be asked to leave the meeting. Repeated violations may lead to removal from the consortium membership.

Appendix I: Tips for Meeting Minutes

- Have a recorder to take the notes at the meetings. This person may be the consortium's coordinator, secretary, or any other member designated to record the events of the meeting.

- Record everything. This does not mean that every word spoken should be recorded, but it does mean that every topic discussed should at least be mentioned. Some topics will require longer discussions than others.

- Include an attendance record as part of the notes. It is always helpful to note who was at the meeting and who was not. This will also help the person responsible for maintaining attendance records.

- Be brief. Use as few words as possible to explain what happened. Members are more likely to read the minutes carefully if they are not too long.

- Distribute the minutes to consortium members, including those who were at the meeting and those who were not. It is also very important to distribute the minutes quickly so that there is time to review them and make necessary changes.

- Maintain confidentiality. Some consortia use only first names in their minutes, some use only initials, while others use full names. It is up to each group to decide. Whatever is decided, the person taking the minutes must be informed. In addition, the person taking the minutes must not identify people as being HIV+ unless they specifically request that they be identified as such.

Appendix J: Sample Confidentiality Sign-Off

As a member of [name of consortium], I understand and agree to the following:

1. [Name of consortium] meetings are open to the public.

2. As a result, nothing said during meetings can remain confidential.

3. Therefore, I will not divulge any confidential information about anyone at a [name of consortium] meeting.

4. If I do divulge confidential information, I may be removed from the consortium membership.

5. If I become aware that someone else has divulged confidential information, I will bring that information to the attention of the chair.

_____ _____

SIGNATURE DATE

Appendix K: Using Data in the Planning Process

The MDPH HIV/AIDS Bureau collects **demographic** and **service utilization** data for all clients receiving services from any agency that receives funding through a consortium. The HIV/AIDS Bureau can also obtain HIV/AIDS **epidemiological** (incidence and prevalence) data for each consortium. This data is used by contract managers to provide a basis for discussion at site visits, to satisfy federal reporting requirements, and to respond to various data requests from legislators and others.

In addition, every consortium must use this data as a basis for making service allocation recommendations. By looking at all three data sources together, a consortium will be able to see an accurate picture of who is being served, what services they are receiving, and what the epidemic looks like in their region.

To obtain the demographic and service utilization data, a consortium must request it from the consortium's lead agency or whichever agency maintains the GenuWin database for the consortium. The epidemiological data may be obtained from the MDPH Web site at http://www.state.ma.us/dph/aids/research.htm. Once the data is obtained, a consortium may begin to use it for service planning.

Sample data reports can be found in Appendices L, M, and N.

These reports can tell you what the service delivery system looks like in a particular area. For example, look at the sample service utilization report to see the total number of clients served by this consortium and compare that with total number of people living with HIV/AIDS within this consortium's catchment area (epidemiological data report). Because the total number of people living with HIV/AIDS in the area (415) is larger than the total number of clients being served (218), a gap in service delivery may be indicated. It would then be up to the consortium to determine why this gap exists and whether or not the situation must be addressed.

Another indicator to review is the service categories being reported. According to the sample service utilization report, there were a total of 187 case management visits and 125 rides from a taxi or other transportation company between October and December 2001. These numbers may indicate that case management is a more popular service than transportation assistance. This information will then be helpful when determining which services to prioritize for funding based on frequency of utilization.

Appendix L: Sample Service Utilization Data Report

Massachusetts Department of Public Health

Standard Utilization Report
Contract Holder: SAMPLE CONSORTIUM

10/1/2001 through 12/31/2001

Service Code	Description	Unit	Participant Males	Participant Females	Participant Total	Session Count (# times recorded)	Total Units Delivered
*	Unduplicated Individuals		128	90	218		
4010	Unknown Code		2	0	2	2	1
4021	Alt. Therapy- Acupuncture	Hour	13	2	15	73	73
4023	Alt. Therapy- Herbal	Hour	0	1	1	1	1
4024	Alt. Therapy- Massage	Hour	6	1	7	24	24
4080	Case Mgmnt, Client- Initial Intake	Started	1	0	1	2	4
4081	Case Mgmnt, Client- Assessment Completed	Completed	3	1	4	6	7
4082	Case Mgmnt, Client- Visit, general	Hour	55	25	80	137	144
4083	Case Mgmnt, Client- Phone, follow-up	Call	64	61	125	239	301
4084	Case Mgmnt, Client- Reassessment	Completed	2	1	3	3	3
4101	Case Mgmnt, Provider- Visit	Hour	7	4	11	13	7
4102	Case Mgmnt, Provider- Phone, follow-up	Call	12	6	18	24	33
4104	Unknown Code		2	0	2	2	1
4108	Unknown Code		0	1	1	1	2
4122	Day Care- Other (hourly)	Hour	0	1	1	1	16
4143	Client Advocacy- Phone, follow-up (BPHC)	Call	1	1	2	3	3
4183	Drug Reimbursement- OTC pharmacy items	Dollars	41	31	72	125	665
4202	Emergency Assist- DPH Direct Client Asst	Indiv	3	2	5	5	5
4223	Food Svc- Meal, congregate	Meal	24	13	37	117	117
4227	Nutrition supplement	Can	13	7	20	38	228
4228	Food vouchers	Voucher	48	37	85	161	165
4242	Homemaker Svcs- Volunteer home visit	Hour	11	2	13	178	154
4361	Peer Support- Session, peer led	Hour	7	2	9	9	9
4364	Peer Support- Session, prof. (DPH)		8	2	10	45	45
4441	Transportation- Public	Fare	19	12	31	56	355
4442	Transportation- Taxi / Transp. Co.	Ride	21	21	42	125	239
4444	Transportation- Volunteer	Ride	12	3	15	32	58
4471	Drop-In Center- Ind. Visit	Visit	39	29	68	210	210
4472	Drop-In Center- Recreational Activity 1	Activity	16	3	19	51	51
4634	Appt. Scheduled- HIV/AIDS Svcs. (TIP)	1 = done	1	1	2	2	2

* Unduplicated count of participants receiving 4000-series services

** Group contacts: Sum of participant counts recorded for 3000-series group services. NOT an unduplicated count of individuals.

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Appendix M: Sample Demographic Data Report

Massachusetts Department of Public Health
Demographic Report
Contract Holder: SAMPLE CONSORTIUM

Report Section	Description	Males	Females	Total	% of Section
All Active Participants	Active Clients(28 new clients)	128	90	218	100
Age	10 to 19 years	0	2	2	1
	20 to 29 years	7	9	16	7
	30 to 39 years	43	38	81	37
	40 to 49 years	55	31	86	39
	50 to 59 years	19	10	29	13
	60 to 69 years	4	0	4	2
Race/Ethnicity	Cape Verdean	1	0	1	0
	Hispanic / Latino	50	31	81	37
	Native American/Aleut/Eskimo	1	0	1	0
	Portuguese	1	0	1	0
	White (not Latino)	55	39	94	43
	Other (AFRICAN)	1	2	3	1
	Other (BLACK)	0	1	1	0
	Other (KENYA)	0	1	1	0
	Other (PORTUGUESE)	1	0	1	0
	Other (SIERRE LEONE)	0	1	1	0
	Undetermined/Unknown	1	0	1	0
	African-American	15	14	29	13
	Asian/Asian American	2	1	3	1
Primary Language	English	79	57	136	62
	Haitian Creole	0	1	1	0
	SE Asian Languages	1	0	1	0
	Spanish	45	29	74	34
	Other (AFRICAN)	0	1	1	0
	Other (ER)	1	0	1	0
	Other (HILI)	1	0	1	0
	Other (Southeast Asian Language)	1	1	2	1
	Other (ZILAND)	0	1	1	0
Diagnostic Information	HIV+ Asymptomatic	60	48	108	50
	HIV+ Symptomatic	39	23	62	28
	AIDS	26	17	43	20
	Not Diagnosed HIV+ / AIDS	0	1	1	0
	Undetermined/Unknown	3	1	4	2
Transmission Category	MSM	23	0	23	11
	MSM/IDU	3	0	3	1
	WSW/IDU	0	1	1	0
	Bisexual	1	1	2	1
	Bisexual IDU	1	0	1	0
	Heterosexual	28	39	67	31
	Heterosexual IDU	64	42	106	49
	Perinatal	0	2	2	1
	Transfusion	1	1	2	1
	Not Dx HIV+ / AIDS	1	0	1	0
	Undet./Unknown	6	4	10	5

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Appendix N: Sample Epidemiological Data Report

Sample Region	
Alive MA HIV/AIDS Cases	
Through 5/2002	
Gender	**Total**
(1)Male	288
(2)Female	127
total	415
Race/Ethnicity	**Total**
(1)White	181
(2)Black	64
(3)Hispanic	154
(4)Asian	14
(5)Indian	1
(9)Unknown	1
total	415
Exposure Mode	**Total**
MSM	69
IDU	174
MSM/IDU	16
Heterosexual	53
Presumed Hetero	79
Other	4
Unk	20
total	415
Age	**Total**
0-12	1
13-19	3
20-24	8
25-29	22
30-34	70
35-39	95
40-44	91
45-49	62
50+	63
total	415

Appendix O: Lead Agency Performance Review Tool

Massachusetts Ryan White Title II HIV Care Consortia
Performance Review of Lead Agency

LEAD AGENCY RESPONSIBILITY	YES	NO	COMMENTS
Collects utilization data from subcontracted providers			
Allows subcontractors enough time to prepare data in time for lead agency to submit data to MDPH			
Collects billing information from subcontracted providers on a monthly basis			
Compiles and submits semi-annual and annual narrative reports to MDPH within specified timelines			
Gives subcontractors enough time to prepare narrative reports			
Reports back to consortium on a regular basis about fiscal, utilization, and service delivery information, including information provided directly by lead agency and by subcontracted providers			

[Continued on next page]

LEAD AGENCY RESPONSIBILITY	YES	NO	COMMENTS
Assures that time and space are available for consortium meetings, announcements and minutes are disseminated appropriately, and interpreting, childcare and other assistance are provided as necessary			
Conducts an analysis of needs assessment and service utilization and presents analysis to consortium			
Works with consortium to revise scope of services and make recommendations to MDPH for contract amendments (based on analysis of needs assessment)			
Provides evidence of all contract assurances required by MDPH (such as consumer representation)			
Distributes MDPH guidance and notices about consortium and CAB activity to all consortium members in a timely manner			

Appendix P: Sample Conflict of Interest Policy

Before a vote on any matter, all members are required to disclose to the consortium any and all possible conflicts of interest regarding the matter. The consortium may request that the member with the conflict of interest abstain from voting. Any member who becomes aware of a conflict of interest on the part of another member must bring that conflict to the attention of the consortium.

A conflict of interest exists when a consortium member would benefit from the outcome of a particular decision. For example, when a provider agency would receive additional funding as a result of a vote, that agency has a conflict of interest for that vote. A conflict of interest also exists when the meeting facilitator may benefit from the outcome of a discussion or decision. In that case, another member should facilitate the meeting. A conflict of interest may be actual or perceived.

Appendix Q: Sample Grievance Procedure

If a member of the consortium or consumer advisory board (CAB) is dissatisfied with a decision made by the consortium, the member may file a grievance. Concerns that may be grieved include decisions about:

- Funding priorities;
- Specific funding decisions;
- Consortium and committee staffing;
- Leadership selection and performance; and
- Consumer involvement and representation in the consortium.

Grievances about any of these decisions may be related to the substance of the decision itself or the process by which the decision was made.

Complaints about services or staff within a particular agency must be directed to that agency. The person making the complaint must follow that agency's own internal grievance procedure. The consortium is not the proper venue to air agency-specific complaints.

A grievance must be submitted in writing to the chair of the consortium no later than two weeks after the decision or event that is being grieved occurred. In some circumstances, at the discretion of the chair, a grievance may be made verbally (e.g., if the person filing the grievance cannot write).

Once the grievance is submitted, the chair may attempt to resolve the situation informally. If informal resolution is not possible, the chair must immediately refer the grievance to the consortium's grievance committee, which must meet within ten business days to address the grievance and must respond to the person filing the grievance within one week after that meeting.

The grievance committee will gather all necessary information and meet in formal session to discuss the grievance. The committee will make recommendations for a resolution and will present those recommendations, in writing, to the consortium at the next regularly scheduled consortium meeting. If the consortium does not accept the committee's recommendations, the consortium must offer an alternative resolution. If no resolution can be reached, the matter will be referred to the consortium's contract manager at the HIV/AIDS Bureau.

If the person filing the grievance is not satisfied with the decision of the grievance committee and consortium, the complainant may appeal to the consortium's contract manager at the HIV/AIDS Bureau.

Appendix R: Request for Technical Assistance Form

Request for Technical Assistance

Date _____

Name _____ Position _____

Consortium _____

Phone number where you may be reached _____

Nature of request _____

Please explain **what** kind of technical assistance you are seeking, **when** you need it, and **how** it would be helpful to your consortium:

What:

When:

How:

Please submit your completed form to your contract manager at:

Massachusetts Department of Public Health
HIV/AIDS Bureau
250 Washington St., 3rd Floor
Boston, MA 02108

FAX: (617) 624-5399